The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

JACOBI MEDICAL CENTER	**1400 PELHAM PARKWAY SOUTH BRONX, NY 10461**	**June 12, 2015**
VIOLATION: *PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION*		**Tag No:** A0123

Based on staff interview and review of Grievance files and Grievance Mechanism policy, it was determined that the facility failed to ensure that written responses to each patient's grievance contained all of the required elements. This was evident in three of three applicable grievances for patients' alleging breach of confidentiality of their medical records (Grievance files #s: #8, #9, & # 10).

Findings include:
Grievance file #7 was reviewed on 6/11/2015. It was noted that the patient contacted the Patient Relation Department, on 5/6/2015, regarding breach of information of her medical record/information to an outside entity. A copy of the written communication to the complainant, dated 6/3/2015, indicated that the patient was informed that the grievance was forwarded to the HIPAA (Health Insurance Portability and Accountability Act) Privacy Officer for a review. It was noted that this complainant was not provided with information on the expected completion of the investigation.

Similar findings were noted grievance file #8 & Grievance #10, who alleged that their medical records/information was breached to an outside entity. They were also informed that the grievances were forwarded to the HIPAA Privacy Officer, but were not informed of the expected completion date of the investigation. The facility received these complaints on 5/13/2015 (grievance file #8) and on 6/2/2015 (grievance file # 10). It was noted that these patients were not informed when they will receive a written response of the outcome of the investigation from the HIPPA Privacy Officer.

In reviewing the facility's Grievance Mechanism Policy section PTS-11 (supersedes 3/2015 and revised on 6/6/2015) on 6/11/2015, It was noted that the policy did not indicate a time frame for investigating and responding to grievances referred to HIPPA Privacy Officers for resolution.

The findings related to grievances that were forward to the HIPPA Privacy Officer for investigation were discussed with staff #1 and staff #2 on 6/11/2015 at approximately 10:15 AM.

VIOLATION: *PATIENT RIGHTS: REVIEW OF GRIEVANCES*

Tag No: A0119

Based on staff interviews, review of the facility's Grievance Summary Log, Grievance Committee minutes, Minutes of the Quality Assurance Committee of the Governing Body and the facility's Grievance Mechanism Policy, it was determined that the hospital's governing body failed to have an effective grievance process as evidenced by the following: 1.) formally delegate the responsibility of grievance committee to a grievance committee; 2.) ensure the prompt resolution of all grievances that the facility received.

Findings include:
1. At interview with Staff #1 and Staff #2 on 6/11/15 at 10:13 AM, Staff #1 stated the facility has recently formed a grievance committee, and the first meeting was in 3/2015. She stated the new grievance committee is responsible for the grievance process, and moving forward it will review and resolve all grievances. However, Staff #1 and Staff #2 were unable to present the documented evidence that the Governing Body delegated the responsibility of the operation of the grievance process to this newly formed grievance committee.

2. The facility's Grievance Committee Minutes for March 13, 2015 and April 27, 2015 were reviewed on 6/11/2015. There were no minutes for the month of May 2015. It was noted that, although grievances were submitted to the facility, from January 2015 - June 2015, not all grievances were reflected in the minutes submitted for review. The March 13, 2015 minutes addressed grievances received for the month of December 2014. Review of the April 22, 2015 minutes noted that the grievance committees reviewed and discussed grievance summaries for the period January 1, 2015 thought January 31, 2015. It was noted that the Grievance Committee discussed 27 cases in April 22, 2015 and it found no quality of care issues. This committee did not address the untimely responses to complainants and steps taken to address the issue of complaints.

Minutes of the Quality Assurance Committee of the Governing Body presented at the annual, Governing Body Meeting was reviewed on 6/12/2015. It was noted that this material was dated 2014. Staff #3 stated that this information was presented on May 28, 2015. There was no evidence the Governing Body was aware that the facility was not providing timely responses to all grievances.

VIOLATION: *PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES*

Tag No: A0122

Based on staff interview, the review of patients' Grievance Files and the facility's policy, it was determined that the facility failed to assure that the timeframe specified in the facility's grievance process for resolving each patient's grievance meets the Federal Requirements within a reasonable timeframe. This was evident in eight (8) of ten (10) Files reviewed (Files #1, #2, #3, #4, #5, #6, # 7, #8).

Findings include:
Grievance file # 1 was reviewed on 6/11/2015. It was noted that the Facility's Patient Relations Department received a complaint from the patient on 2/8/2015. The patient alleged several issues that she encountered while she was in facility Adult Emergency Department (AED) on 2/5/2015. In this grievance, the complainant listed: several environmental and infection control issues, lack of nursing care and postponing of surgery, as reasons for the complaint. It was noted that the investigation was completed by Nursing Department on 2/12/2015. The Patient Relations Department received the Environmental Services response on 3/16/2015. As of the day of the review, on 6/11/2015, there was no evidence that the complainant was provided with a written response on the outcome of the investigation or documented in the file the reason for the delay.

Grievance file # 2 was reviewed on 6/11/2015. It was noted that the facility received the complaint on 2/8/2015. The complainant alleged that there was "false information" on her discharge papers from her AED visit on February 4, 2015. It was noted that the facility investigated the complaint. It was determined that the patient was given a generic discharge summary given to all patients who were discharged from the AED. It was noted that determination was made on 2/26/2015. However, the final response to the complainant was dated 5/11/2015, over two months later.

Grievance file # 3 was reviewed on 6/11/2015. It was noted that the facility received a complaint from a parent, on 3/5/2015, regarding the patient's encounter in the facility's

Pediatric Unit on 1/19/2015. The patient expired and the father was requesting a copy of the medical record. It was noted that it took the facility over 30 days (4/9/2015) to inform the complainant that they were responding directly to the patient's mother on the outcome of the investigation, as she was the legal guardian. The letter to the mother was also dated 4/9/2015 took over 30 days; it notes, that "at present we cannot provide you with information as the cause of death is unknown".
Grievance file # 4 was reviewed on 6/11/2015. It was noted that the facility's Patient Relations Department received the complaint from a patient's mother, on 4/6/2015, who requested to make a formal complaint about the Phlebotomy Department. It was noted that the Phlebotomy Department response was received on 5/28/2015. It was noted that, a copy of a letter to the complainant was dated 6/8/2015, indicated that the results of facility's investigation would be sent within 30 days". It was noted as of the day of the review, on 6/11/2015, the complainant was not provided with a written response on the outcome of the investigation.

Similar findings related to delay in grievance responses was noted in grievance file #5; the complaint was dated 4/22/2015, but the written response to the complainant was dated 6/10/2015. Grievance file #6 had a complaint dated 5/6/2015 and a written investigation response to the complainant was dated 6/10/2015. Grievance file # 7 had a compliant dated 5/13/2015 and a response dated 6/3/2015. Grievance file #8 dated 5/6/2015, the investigation was completed on 6/3/2015, but written response to the complainant was dated 6/10/2015.

Grievance Mechanism section PTS-11, supersedes 3/2015 and revised on 6/6/2015, was reviewed on 6/11/2015. This policy indicated, "When a grievance is received the Patient Representative will provide a written response to the complainant, within 7 days, acknowledging that the grievance has been received and investigation will be completed within 30 days". It was noted that the facility was using 30 days as a time frame for resolving and responding to all grievances. Although the facility revised its Grievance Mechanism, its investigation timeframes continue to be late.

At interview with Staff #1 and Staff #2 on 6/11/2015 at approximately 10: 13 AM, they acknowledged that regulatory requirements for prompt resolution of grievances were not met.

VIOLATION: *PATIENT RIGHTS: EXERCISE OF RIGHTS*

Tag No: A0129

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of medical record and Patient Rights information, it was determined that the hospital failed to afford each patient/representative the right to receive current and ongoing information concerning patient ' s diagnosis, treatment and prognosis. This was evident in 1 of 5 medical records reviewed (MR #2).

Findings include:

Medical record for Patient #2 was reviewed on 6/12/2015. The patient is a 19- year-old female with no know medical problems was admitted to the facility's Labor and Deliver unit on 3/26/2015 at 8:40 PM. The patient delivered a live baby girl via vacuum assisted vaginal delivery on 3/27/2015 at 10:48 AM. The patient developed massive hemorrhage before and after delivery and was found to have a vaginal laceration, requiring repair. Post-delivery and surgical repair of vaginal laceration and laparotomy, the patient ' s medical condition deteriorated requiring management in the Surgical Intensive Care Unit. The patient was transferred to the SICU (surgical intensive care unit) intubated in critical condition. The patient expired on [DATE] at 7:34 PM.
OB Attending progress note dated 3/27/2015 2016 (8:16 PM) indicated that the physicians and the nursing staff met with the patient ' s family and pastor to notify them about the death of the patient.
There was no documentation in the medical record to indicate the patient's representative was informed of the changes in the patient ' s medical condition after she was transferred from the OR. It was noted that the patient remained in the SICU over six hours prior to her demise. The medical team did not meet with the patient's family and provide an opportunity for visitation prior to the patient expiration.

VIOLATION: *PATIENT RIGHTS: RESTRAINT OR SECLUSION*

Tag No: A0168

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on staff interview, review of medical record, and other documents, it was determined that the hospital failed to ensure that each patient is restrained in accordance with the order of a physician or other licensed independent practitioner. This finding was noted in the review of one of three applicable medical records for patients with restraints applications (Patient #1).

Findings include:
The facility's Occurrence log, for the Months January 2015 to May 2015, was reviewed on 6/11/2015. It was listed on this log that the patient in MR #1 was restraint chemically and the patient was also on 4 PT (points) restraint. A detailed information, regarding this occurrence, was documented on the facility ' s " Patient Profile Form " , dated 3/15/2015, was reviewed on 6/11/2015. This form indicated that "PT (patient) was in 4PT (points) restraints. Restraints & was restrained chemically both bilateral hands restraints off. PT (patient) found sitting on bottom with bilateral ankle restraints attached to bed".

Medical record for Patient #1 was reviewed on 6/12/2015. This [AGE]-year-old with history of seizure and hypertension (HTN) with unknown psych history presented to the facility's Emergency Department by ambulance on 3/15/2015 with a chief complaint that she fell at home. In addition, the patient was unable to sleep for four days. The patient was triaged on 3/15/2015 at 0627 (6:27 AM) and she was placed in triage category ESI (Emergency Severity Index) - 3.

On 3/15/2015 0820 (8:20 AM), the nurse noted that the patient was given "Haldol 5mg & Versed 2 milligram (mg) by other RN as ordered by MD". The nurse noted that the patient refused to stay lying down and the patient's son assisted in keeping the patient on the stretcher.

The physician ' s order for the restraint was reviewed. It was noted that the physician wrote restraint on 3/15/2015 0913. The type of restraint was 2 points (wrists) restraints. The physician note restraints is indicated because the patient was climbing out of bed/chair and the alternatives to restraint is medication management.

The first medical assessment, located in the record, was dated on 3/15/2015 at 1041. The physician noted that the patient was agitated and uncooperative asking to leave and the plan to transfer the patient to psych unit after medical evaluation was complete. It was noted that the MD assessment did not include if restraining this patient both chemically and physically was appropriate treatment for the management of her condition.

It was noted that on 3/15/2105 at 1156 (11:56 AM), the restraint order was renewed for 2 points (wrists). The physician note, " patient is trying to elope; Alternative: frequent reorientation".

On 3/15/2015 1159 (11:59 am) the nurse noted "patient was in 4 point restrains, bit thought wrist restraints found on floor sitting on bottom with legs still restrained, no visible injuries at this time, incident report filled, charge nurse and attending aware. While retrieving sedative medication patient again was attempting to sit forward and remove self from bed. Pt wriggled left (L) wrist free from restraint, Pt re-secured, given 50 mg Ketamine, as per MD " .

Staff # 4 was interviewed on 6/11/2015 at approximately 2:45 PM. It was brought to the staff attention that this was in 4-point restraints as well as chemically restraints. Staff #4 stated the patient was not chemically restrained but was medicated to treat her symptoms. Staff #4 stated that based on this restraint incident, the Emergency Department staff was re-educated on restraint use.

On 6/12/2015, Staff # 4 submitted documentation regarding the staff re-education (curriculum and sign-in sheet) on restraint. The training was conducted in April and May 2015

with nursing staff. It was noted that the facility's staff training was inadequate, as the management of patients in chemical restraints was not covered. In addition, the training did not include that restraints must only be applied in accordance with a physician order or other licensed Independent Practitioner.

VIOLATION: *PATIENT RIGHTS: RESTRAINT OR SECLUSION* | **Tag No:** A0175

Based on staff interview, review of medical record and hospital ' s policy, it was determined that the facility failed to ensure that patient in MR # 1 who was placed in chemical and physically restrains was properly monitored. This was evident in 1 of 3 applicable medical records review (MR #1).

Findings include:
Review of MR #1, on 6/12/2015, noted that on 3/15/2015 1159 (11:59 am) the nurse noted "patient was in 4 point restrains, bit thought wrist restraints found on floor sitting on bottom with legs still restrained " . The nurse also notes, " Pt wriggled left (L) wrist free from restraint, Pt re-secured, given 50 mg Ketamine, as per MD " .

The physician ' s orders for the restraint were reviewed. It was noted that the physician wrote an order for 2 points (wrists) restraint on 3/15/2015 0913. A new restraint order was written on 3/15/2105 at 1156 (11:56 AM) for 2 points (wrists) restraints.
The Restraint Flowsheets located in the record was reviewed. It was noted that the record did not include the Flowsheet for restraints order for 3/15/2915 0913 (9:13 AM).

The Flowsheet dated 3/15/2015 1157 (11:57 AM) contained staff initials every 30 minutes from 12:00 (12:00 PM) to 13:00 (1:00 PM) indicating that the patient was monitored for one hour while in restraints. The Flowsheet form indicated that Patients in Limb Restraints must be monitored every thirty minutes. This form did not indicated how often patients placed on chemical restraints are monitored.

" Nursing Restraints Policy Section PTC " last revised 4/2015 and " Seclusion and Restraint Behavior Health - Inpt 2.03; CPEP 2.15 " policy last reviewed 5/15 were reviewed on 6/12/2015. These policies note that a patient in limb restraints for behavioral reasons must be monitored every fifteen minutes. It was noted that this patient was monitored every 30 minutes and not every fifteen minutes as prescribed by the policy. In addition, the facility's restraint policy did not include how to monitor patients placed on chemical restraints.
The Flowsheet monitoring form was brought to Staff # 4 attention on 6/12/2015 at approximately 11:00 AM. Staff #4 stated that the initials on the form represented staff monitored the patient and she confirmed the patient was only restrained for one hour and assessed every thirty minutes. The nursing staff responsible for the care of the patient was not available for an interview.

VIOLATION: *MEDICAL STAFF* | **Tag No:** A0338

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interviews, review of medical record and other documents, it was determined Medical Staff failed to provide timely care for a patient with severe intrapartum (Occurring during labor or delivery) blood loss. Specifically, the facility's guidelines for postpartum hemorrhage and activation of OB (Obstetric) Stat Team were not promptly implemented. This finding was noted in 1 of 6 applicable maternal records reviewed (Patient #2).

Findings include:

Patient #2 is a [AGE] year-old female, Gravida -0 (Number of pregnancies), Para - 0 (Number of births greater than 20 weeks) who presented to Labor and delivery on 3/26/15 at 41 weeks 3 days gestation for post-dates induction of labor.

On 3/26/15 at 8:40 PM, Certified Nurse Midwife (CNM), Staff #5 notes the following assessments: vital signs - Blood pressure 117/62, Temperature 98.1 degree Fahrenheit, Respirations 18. Estimated fetal weight by ultrasound was 8 pounds 9 ounces, Fetal Heart tracing at 135 beats per minute.

Staff #1 documented the first dose of Cytotec (indicated for induction of labor) 50 microgram (mcg) was administered buccally (medication placed inside the cheek) on 3/26/15 at 8:50 PM, and a second dose on 3/27/15 at 05:08 AM while being monitored for labor progression.

On 3/27/15 at 06:00 AM, Epidural catheter placed and vital signs monitored every fifteen minutes.

At 09:40 AM, Vaginal examination by CNM revealed fetal descent/100percentage effacement /+1 station. CNM notes patient's membranes were artificially ruptured and clear fluid was noted.

At approximately 10:30 AM, CNM reported heavy vaginal bleeding following vaginal examination. The patient was noted to have a laceration on the right side of vagina/labia minora. The Labor and Delivery attending, Staff #6 arrived at patient's bedside at 10:32 AM followed by a junior attending, Staff #7 at 10:37 AM.

The medical team members upon estimation of blood loss failed to implement the facility's hemorrhage protocol.

The facility's "Hemorrhage Protocol: Guidelines for Obstetrical Practice" last revised February 2013 defines significant postpartum hemorrhage as Estimated Blood Loss (EBL) greater than 500 centiliters (cc) following vaginal delivery, EBL greater than 1000 cc following a cesarean section and hemodynamic instability. The hemorrhage Protocol prescribed a series of task that includes assessments, medications/procedures, as well as Blood Bank notification and transfusions to be completed for the three stages of blood loss. For Stage 3 blood loss (Blood loss of over 1500 cc, the protocol recommends activation of "Massive Transfusion Protocol ".

On 3/27/15 at 10:47 AM, the patient had terminal Bradycardia, requiring delivery of the child by vacuum extraction at 10:48 AM.

The patient received the first and second blood transfusion on 3/27/15 at 11:50 AM and 11:55 PM respectively; this was over one hour after Staff #1 and Staff #2 observed massive blood loss estimated at 1500 cc.

Consequently, on 3/27/15 at 11:27 AM, the patient became hemodynamically unstable with hypotension and changes in mental status.

In addition, the Obstetric Care team failed to activate "OB stat Team" as prescribed by the facility's policy for management of emergencies.

The facility's policy titled "OB Stat Team" last reviewed October 2012, notes, "the purpose of the OB Stat Team is to provide rapid, organized, efficient response to obstetrical emergencies and improve maternal and neonatal outcomes. " The policy notes that "Any clinical staff member that identifies that an obstetrical patient is experiencing a sudden change in physiologic status or feels uncomfortable with a patient condition/situation and desires additional help, can activate the OB Stat Team. " A list of situations that may trigger the notification of the OB Stat Team is listed in the policy, and it includes "Maternal hemorrhage".

The OB stat team was called by an attending physician on 3/27/15 at 11:27 AM at the time when the patient decompensated; there was a delay of about one hour after maternal hemorrhage was first identified.

The Massive Transfusion Protocol was call stat by the CNM on 3/27/15 at 11:33 AM, a delay of over one hour from when maternal hemorrhage was first identified.

At interview with staff #6, OB attending on 6/11/15 at 11:20 AM, he stated that when he entered the room on 3/27/15 at about 10:32 AM, he found the patient had a deep vaginal laceration on the right labia and saw arterial blood vessel that was pumping. He stated that he estimated the blood loss at 700-800 cc. However, a late note by Staff #7, junior attending on 3/27/15 at 3:08 PM indicated that the blood loss at the time of response on 3/27/15 at 10:37 AM was about 1500 cc. Staff #6 further stated he did not immediately call for massive transfusion protocol, but ordered two units of packed red blood cells (PRBC) to be transfused. He reported that while he was repairing the patient's laceration, he was not aware staff members were having difficulties obtaining a venous line for the transfusion of the blood. He stated he would have stopped the infusion of Pitocin to transfuse the two units of PRBC.

The patient was taken to the operating room after delivery on 3/27/15 at 11:30 AM, where she underwent repair of mid-vaginal tear and subsequently an exploratory laparotomy that did not identify additional source of bleed. Post operatively, the patient's condition was critical; the patient coded several times and she expired on [DATE] at 7:34 PM.

VIOLATION: *FORM AND RETENTION OF RECORDS*

Tag No: A0438

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview, hospital policy, and other documents, it was determined the hospital failed to maintain each patient record. Specifically, the facility failed to ensure that medical records: 1.) Are accurately written in 1 of 5 records reviewed; 2.) Timely completed upon discharge of patients in 32 of 50 applicable records; and 3) protected from damage.

Findings include:

1. The record for Patient #2 was reviewed on 6/12/2015. It was noted that the patient #1, [AGE]-year-old female, was admitted to the facility's Labor and Delivery unit on 3/26/2015. This patient delivered a live female baby on 3/27/2015 at 10:48 AM. The patient expired on [DATE] at 1934 (7:34 PM).

It was noted that the time the patient arrived in the Surgical Intensive Care unit, the Admission Assessment, Discharge Summary and the time of death were not consistently documented in the medical record.

For example:

The Med/Surg transfer in summary indicated that the patient was transferred to the SICU unit on 3/27/2015 at 1230 (12:30 PM). However, the nursing delivery note dated 3/27/2015 at 1756, indicated that the patient was transferred to SICU at 1:22 PM.

The Critical Care Admission assessment dated [DATE] at 1300 (1:00 PM) indicated that the patient was admitted on [DATE] at 2015 (8:19 PM). Based on documentation, on the Death Work Sheet, the patient expired in the unit on 3/27/2015 at 1934 (7:34). It was documented in the Critical Care Admission Assessment the patient did not want to see any

member of the clergy; however, it was noted that this patient was intubated prior to transfer to the unit. In addition, The Critical Care Admission Assessment indicated that the patient had a C-section on 3/27/2015 at 2015 (8:15 PM). There was no documentation in the record that this patient had a C-section.

It was noted that the Death Note (MD) dated 3/27/2015 at 2137 (9:37) indicated that the time of death was "Fri, 27 [DATE] (7:34 PM)". However, this same physician documents in the progress notes "patient declared by SICU and OB GYN attending at bedside at 1734 (5:34 PM)".

The Death Procedure Worksheet dated 3/28/15 at 1002 (10:02 AM) indicated that the time of expiration was 3/27/15 at 1934. The OB Attending Progress note, dated 4/16/2015 at 1445, indicated that the patient was declared dead in the SICU at 5:34 PM (1734).

The facility's policy Content of the Medical Record revised 5/28/15 was reviewed on 6/12/2015. This policy indicated that the entries in the medical record should be legible, complete, dated, and timed. This policy did not indicate medical record entries should be accurately timed.

2. Twelve medical records were found Incomplete/delinquent over 90 days and twenty medical records were found incomplete/delinquent over 180 days (6 months). These medical records were missing History & Physical, operative reports, and discharge summaries.

At interview with the Network Director of Health Information Management (HIM), Staff #8 on 6/9/15 at approximately 11:00 AM, he stated that medical records identified as incomplete are flagged. The Network Director HIM would contact the physician by telephone and/or e-mail and inform him/her of the deficit. If the medical record continues to be incomplete at 30 days, the next step would be to contact the Chairman of the Medical Department. This would be the last step of the process.

The hospital policy on timeliness of medical records was not implemented.

Review of the facility's policy titled, " Timeliness of Medical Record Documentation" notes that "medical records shall be completed within 30 days of the patient's chart " .

3. During a tour of the Medical Record Department conducted on 6/9/15 at approximately 10:30 AM, medical records were observed stored on open shelves beneath sprinklers. The medical records were not protected from water damage.

At interview with Staff #8 and Staff #9, Director of Information Systems on 6/9/15 at approximately 10:30 AM, they reported they are aware of the potential risk for water damage in the medical record storage area, but have not yet implemented actions to safeguard the medical records.

VIOLATION: *EMERGENCY SERVICES POLICIES*	**Tag No:** A1104

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interviews, review of medical records and other documents, it was determined the facility failed to ensure that each patient presenting to the Emergency Department receives timely evaluation and treatment in accordance with its written policy and procedure. This finding was noted in 1 of 9 applicable medical records reviewed (Patient #3).

Findings include:

Patient #3 (MDS) dated [DATE] at 7:16 AM with complaint of abdominal pain. The patient was triaged at 07:50 AM with vital signs as follows: Temperature 99.7 Fahrenheit; Pulse 102; Respirations 18; Blood Pressure 130/80; Pulse oximetry- 99%; Pain rated at 8 on a scale of 1-10. Triage nurse noted the patient was alert and oriented, no overt distress or vomiting noted, patient is not guarding his stomach and sepsis was not suspected. The triage classification was a Level-3. The patient was noted to have departed the Emergency Department on 5/7/15 at 10:15 AM without a Medical screening evaluation; this was about three hours from the time of arrival.

During the tour of the Emergency Department on 6/09/15 at 11:40 AM, Staff #10, Director of Adult ED was interviewed regarding triage process and wait times for medical screening evaluation. She stated that upon arrival of a patient, a nurse (E-Fast Nurse) greets the patient and conducts a quick assessment of the patient and determines if the patient needs to be seen immediately, or can wait in the waiting area for a full triage assessment. She stated patients with chest pains, breathing difficulties and other patients with trauma or in acute distress are taken into the ED treatment area and triaged at the bedside. She reported the average time from door to triage is about 10 minutes and the average timeframe for initiation of treatment for a patient classified as a Level-3 is within 1 to 2 hours.

The facility failed to implement its triage policy for prompt evaluation and treatment of the patient's medical condition. The facility's policy titled "Triage of adult/Pediatric Emergency Department Patients" last revised in August 2012 notes the timeframe for initiation of treatment for patients triaged as Level- 3 is 1-2 hours. In addition, the policy notes "Reassessment of patients waiting for diagnostic evaluation and treatment is based on the triage level assigned. Level 3 patients must be reassessed within 2 hours in the event that they were not evaluated within the specified timeframe."

The patient did not receive a Medical Screening Evaluation within one to two hours of arrival in the Emergency Department, and he was not reassessed within two hours of triage as specified in the facility's triage policy.

At interview with the Patient #3 over the phone on 6/15/15 at 3:17 PM, he stated he departed the ED after waiting over three hours for physician evaluation and treatment of his medical condition. He reported that after three hours of waiting in the ED, he approached a staff member who told him there were four people ahead of him and the wait time was going to be at least another hour before he is evaluated. He stated that when he departed the ED sometimes after 10:30 AM, his abdominal pain had worsened and was unbearable. He reported he went directly to an outpatient clinic where he was triaged with a temperature of 102 degrees Fahrenheit and he was later diagnosed as having a colon infection.